FINANCIAL INCENTIVES FOR PROVIDERS IN MANAGED CARE PLANS FINDINGS AND RECOMMENDATIONS

I. FINDINGS

Physicians and other appropriately-licensed health professionals operating within the scope of their practice (i.e., health practitioners or providers) are motivated by many incentives. Compensation arrangements are one important factor that may impact the quality and cost of care. Other, arguably more, important factors at work include professional ethics and providers' desire for the esteem of their peers. These incentives drive practitioners to give good care and work hard regardless of how they are paid.

All compensation arrangements contain incentives which may have positive and negative effects. Under fee-for-service (where payment occurs only if service is rendered), health practitioners have incentives to provide at least the care, and sometimes more care, than patients need. Payment on a capitation basis (where prepayment for the potential use of services occurs regardless of whether or not care is rendered) may create incentives to provide appropriate care, or to provide less care than needed. Compensation through salary provides an incentive to provide appropriate care, but may impede productivity. Many providers participate in bonus and withhold incentives arrangements which may be designed to encourage quality and consumer responsiveness, or may be weighted excessively toward financial considerations.

There are almost an infinite array of compensation arrangements. These arrangements are often very complex and therefore, in most instances, not amenable to regulation. Nor is there direct conclusive evidence of the relationship between specific financial arrangements and adverse outcomes. However, some arrangements are not in the public interest and should be restricted because they create too great an incentive to deny necessary medical care. In general, the greater the intensity of incentives, the more likely they are to affect specific clinical decisions. Of particular concern are incentives which place individual or small groups of health practitioners at risk for the cost of referrals for their patients. Stop-loss insurance, reinsurance, and especially risk adjusted payments to providers can alleviate some of the potential problems associated with capitation.

According to one national survey of physicians and managed care plans, approximately half of all American physicians have at least some patients whose insurance plans place the physician at some financial risk. Health plans reported an average of 12% as the maximum percentage by which an individual primary care physician's annual income may vary each year as a result of financial incentives.[1]

Both federal law[2] (applicable to Medicare and Medicaid patients) and state law[3] prohibit arrangements that are an inducement to limit or reduce necessary services to an individual enrollee. Federal law also requires that physicians who are placed at substantial financial risk have specified stop-loss protection.

---

[1] Gold M, Hurley R, Lake T, et al., "Arrangements between managed care plans and physicians. Selected external research series no. 3.," Washington, DC: Physician Payment Review Commission, 1995.
[2] Sections 4204(a) and 4731, OBRA 1990, Public Law 101-508; and HCFA Regulations 42CFR, Section 417.479.
[3] AB 2649, 1996, now part of Knox-Keene Act Section 1367.10.

Though the information is complex, patients and enrollees may benefit from disclosure of financial incentives by health plans and medical groups. State law requires health plan disclosure of incentives. Federal law (for Medicare and Medicaid patients) requires disclosure of incentive arrangements where physicians are placed at substantial financial risk. Disclosure by individual practitioners may also benefit patients provided it is done in a manner that is sensitive to the provider-patient relationship. However, practical implementation of further disclosure requirements may be difficult, though worth exploring.

Health plans, purchasers, government entities, and accreditation agencies have not sufficiently researched and identified provider compensation arrangements that produce the most appropriate care and best outcomes.

The Department of Corporations (DOC) or other state oversight agency would benefit from ongoing expert advice in assessing compensation arrangements.

II. RECOMMENDATIONS

1. Health plans should be required to disclose to the public the general methods of payment made to their contracting medical groups/IPAs or health practitioners and the types of financial incentives used. Disclosure should use clear and simple language, including a suggestion that if an individual wishes to know more about their providers' or provider groups' method of reimbursement, they can ask their medical group/IPA, provider, or health plan.

2. The DOC should conduct a pilot project with a variety of medical groups and other provider groups to develop clear, simple, and appropriate disclosure language (field-tested for consumer understanding and value) and the most cost-effective methods for distribution to enrollees. The DOC should report results back to the legislature to consider how best to approach provider group disclosure.

3. Provider groups and health practitioners should be required to disclose the method of compensation and financial incentives they receive, upon the request of a patient. Provider groups should also be required to disclose the methods of compensation and incentives paid to their subcontracting providers.

4. (a) Health plans and provider groups should be prohibited from adopting an incentive arrangement in which an individual health practitioner receives a capitation payment for professional services that includes the cost of referrals for that practitioner's patients.
   (b) Where an individual health practitioner receives an incentive tied to the cost of referral of that practitioner's patients or where a very small group receives such an incentive or a capitation payment for professional services that includes the cost of referrals for the group's patients, it should not be approved by the DOC in the absence of a determination that there is a patient panel of sufficient size to spread risk and there are adequate provisions to assure quality care and to protect against high risk cases through stop-loss or risk adjustment.

(c) The federal rule requiring the provision of stop-loss coverage for health practitioners at substantial financial risk should be extended by state law to practitioners treating commercial patients.

5. Sponsored purchasing groups, such as PBGH, and accreditation organizations, such as NCQA, should review provider incentive compensation arrangements (including non-financial incentives) to identify best practices and practices in need of improvement, and seek to influence plan and provider groups accordingly. Particular attention should be paid to the promotion of risk factor measurement (e.g., morbidity and mortality rates) and risk adjustment.

6. An industry group should be formed by the California Medical Association, California Association of Health Plans, American Medical Group Association, and the National IPA Coalition to review provider compensation arrangements, identify best practices and practices in need of improvement, and advise regarding the need for changes in regulatory oversight.

7. Major purchasers should consider Task Force recommendations to them regarding risk adjustment (See recommendations in Task Force paper on Risk Avoidance).

FINANCIAL INCENTIVES FOR PROVIDERS IN MANAGED CARE PLANS[4] BACKGROUND PAPER

I. INTRODUCTION

Enrollment in health maintenance organizations (HMOs) and other forms of managed care continues to grow in California. Although most enrolled residents of the state are accustomed to their pre-paid health system, there are concerns that the financial incentives in some managed care arrangements could erode the basic tenets of the provider-patient relationship and undermine quality of care.[5] Managed care changes traditional unmanaged fee-for-service ("indemnity") insurance by integrating the financing and delivery of health care services, with the aim of controlling costs and improving quality.

Physicians and other appropriately-licensed health professionals operating within the scope of their practice (i.e., health practitioners or providers) have incentives other than financial which drive them to give good care and work hard regardless of how they are paid. These include a desire to make people well, to solve scientific problems, and to win the respect of colleagues.

This paper will outline: (1) the range of provider incentive models that are currently being used in California and around the country, (2) issues that must be considered in structuring these compensation plans, (3) research that attempts to determine whether managed care can decrease utilization while preserving quality of care, (4) governmental responses that have occurred at both the Federal and State levels to the issue of financial incentives for health practitioners, (5) the issue of disclosure of incentive information to consumers, and (6) general findings and recommendations.

II. MODELS OF PROVIDER COMPENSATION AND INCENTIVES

In general, managed care plans compensate health practitioners using a combination of basic reimbursement and incentive reimbursement. Basic reimbursement models include (1) fee for service (FFS), (2) salary, and (3) capitation. Practitioners receive the bulk of their compensation from their basic reimbursement. These forms of basic compensation have inherent in them different incentives that can affect provider behavior in different ways.[6] Under FFS, providers are paid for each procedure or treatment they perform, and providers (unless their practice is too busy) may have an incentive to "over-treat" the patient. In some cases, there may be risk to the patient from such over-utilization of services.[7] Early utilization review methods were designed to detect this type of overuse of services. Under a salary arrangement, a health practitioner receives a fixed amount from the health plan (i.e., health insurance arrangements, also known as health benefits financial intermediaries) no matter what services he or she provides. The practitioner therefore has little financial incentive to provide too many or too few services. However, some critics of salaried arrangements point out that salary leaves no immediate direct financial incentive to increase productivity. With individual provider capitation, the provider

[4] Based on a paper written by Margaret Holland, Stanford University, Graduate School of Business, Spring 1997.
[5] Newhouse J, et al., "Risk Adjustment and Medicare: Taking a Closer Look," *Health Affairs*, 16:5, September/October 1997, 26-43.
[6] Latham S, "Regulation of managed care incentive payments to physicians," *American Journal of Law & Medicine*. 1996:XXII(4):399-432.
[7] Wilson, CM, et al. "The Appropriateness of Performng Coronary Artery Bypass Grafts," *JAMA*, July 22, 1988.

receives a fixed fee per member enrolled in a particular health plan and is at risk to provide a set of services within that fixed amount. The capitation payments received on behalf of the majority of members subsidize the costs of care of those few who are sick. Still, capitation of individual health practitioners has been criticized as providing an incentive to provide too few services.

Health plans often try to enhance or temper the incentives built into basic reimbursement models by using targeted incentive payments such as (1) bonuses, (2) withholds, and (3) sub-capitation. Incentive payments can be used to elicit a range of desired behaviors from providers. They can also be used to encourage the provision of certain types of services, such as preventive care or counseling. For example, where the basic compensation is FFS, a health plan may use incentive payments to encourage cost-effective care. Where the basic compensation is capitation, a health plan may give incentive payments to reward quality. Often plans will use a combination of basic reimbursement and multiple incentive plans.

Bonuses are rewards. Health practitioners can receive extra money if they meet certain performance criteria. The performance criteria can be either financial or non-financial or both. As an example of financial criteria, the amount of the bonus may increase as the plan's expenditures for patient care decrease. Non-financial criteria can include measures of outcomes, patient satisfaction and peer evaluation. Bonuses may be used by groups that pay practitioners on a FFS or salary basis as a way to encourage certain types of behavior.

Withholds are delayed payments, conditioned upon performance. Rather than receive their full basic reimbursement up front, practitioners only receive a percentage. The remainder is withheld by the health plan and typically put into a risk pool. Funds in the risk pool can be used, for example, to pay for referral or laboratory services authorized by the practitioners. Providers receive money from the risk pool at the end of the compensation evaluation period if costs have not exceeded budget. Plans vary on how they fund deficits in withholding accounts. Some of the options include increasing the percentage of payment withheld each year, liens on future earnings, or exclusion from the program. Some plans require that the providers repay the entire deficit amount, while others restrict this amount to a set percentage or amount per enrolled patient per year. Others retain reinsurance or stop-loss coverage to prevent such an eventuality. Withhold arrangements are used with FFS or capitation arrangements.[8]

Under sub-capitation, a provider group receives capitation for a group of patients, and in turn subcontracts with certain providers, also on a capitated basis, to provide services.

III. GROWTH OF INCENTIVE ARRANGEMENTS

As managed care has spread throughout the country, so has the use of incentive arrangements. The Physician Payment Review Committee (PPRC) recently released two reports documenting the extent and growth of incentive arrangements nationally. They conclude that approximately half of all American physicians have at least some patients whose insurance plans place the physicians at financial risk through the use of capitation or of withhold modifications to

[8] Op-Cit., Latham S, *American Journal of Law & Medicine*, 1996.

indemnity plans.[9] The studies also suggest that capitation arrangements are more common among primary care physicians and among physicians in group practices with over twenty-five physicians. Withhold-modified FFS arrangements are most common overall and are especially predominant among specialists and physicians in small practices.

Latham comments,

> [d]ata from managed care organizations echo this physician data. The PPRC study of managed care plans indicated that nineteen percent of plans use salary as basic payment, thirty-seven percent use capitation and forty-three percent use FFS (see Figure 1). Twenty-five percent of FFS plans modify their basic payments with withholds or bonuses, as do over half of salary plans. Thus, over sixty percent of managed care plans place physicians at some risk, either through capitation or through withhold or bonus modifications of salary and FFS-based payment.[10]

Further, 56% of the network or independent practice association (IPA) HMOs used capitation as the predominant method of paying PCPs, as compared with 34% of the group or staff HMOs and 7% of the preferred provider organizations (PPOs).[11] Withholds and bonuses are most common among network- and IPA-model HMOs. Seventy-two percent of these HMOs use withholds or bonuses in paying their PCPs, and 47% use them for payment of specialists.[12] A majority of HMOs (68.8%) adjust capitation payments to medical groups to account for differences in patients by age and gender; however, only 10.3% adjust for disease severity according to a recent survey by PBGH.[13] Most of the HMOs under contract to PBGH capitate medical groups with large case loads that may represent an average risk pool, so risk adjustment may or may not be appropriate.

[9] Op-Cit., Gold M, et al., "Arrangements between managed care plans and physicians. Selected external research series no. 3.", 1995.
[10] Op-Cit., Latham S, *American Journal of Law & Medicine*, 1996.
[11] Gold MR, Hurley R, Lake T, Ensor T, Berenson R, "A national survey of the arrangements managed-care plans make with physicians," *NEJM* 1995; 333:168-83.
[12] Op-Cit., Gold M, et al., "Arrangements between managed care plans and physicians. Selected external research series no. 3.", 1995.
[13] "The Physician Group Assessment of HMO Performance, 1997", Pacific Business Group on Health. Data comes from assessment of 272 physician group contracts in California, Washington, and Oregon. The survey question does not distinguish whether HMOs adjust all or only some of their payments to physician groups.

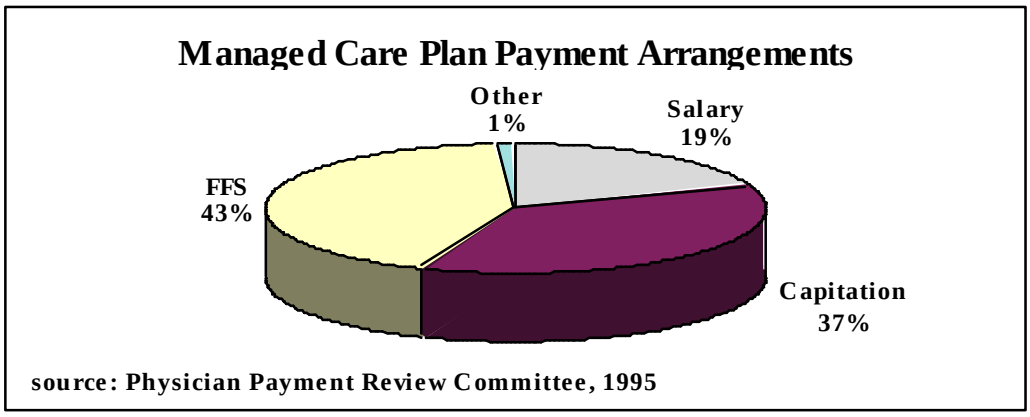

Figure 1

A study using data from a 1995 AMA survey of physicians found that capitation of physician practices is widespread and that physician involvement with capitated contracts increased sharply between 1994 and 1995. The study found that "as of mid-1995 more than 33% of patient care physicians were in a practice that had a least one capitated contract, up from 26% in 1994."[14]

A 1995 study by Robinson and Casalino documents the growth of capitation at six large medical groups in California. They found that between 1990 and 1994, the number of HMO enrollees whose care was paid for through capitation increased by 91%.[15] These groups did not pay their member physicians through capitation, but rather paid a salary plus an annual bonus based on the physician's productivity, patient's satisfaction, and profitability of the group.

IV. ISSUES AND TRENDS IN PROVIDER FINANCIAL INCENTIVES

Financial incentives for health practitioners practicing in managed care settings are indisputably complex. As Dr. Alan Zwerner of the American Medical Groups Association said, "if you've seen one incentive plan, you've seen one incentive plan."[16] However, several common characteristics and issues emerge from the literature that should be considered by policy makers debating this topic.

A. Two-tiered vs. Three-tiered Health Plans

Different contracting arrangements can elicit different types of provider behavior. Two-tiered HMOs are HMOs that contract directly with providers. Three-tiered HMOs are HMOs that contract with intervening entities such as medical groups, which then contract with providers.[17] In three-tiered HMOs, the intervening entities may change the financial incentives so the HMOs do not directly impact the provider. In evaluating financial incentive arrangements, it is not

[14] Op-Cit., Simon CJ, Emmons DW, *Health Affairs* 1997.
[15] Robinson JC, Casalino L, "The growth of medical groups paid through capitation in California," *NEJM* 1995, 333:1684-87.
[16] Personal interview, June 10, 1997.
[17] Hillman AL, Welch WP, Pauly MV, "Contractual arrangements between HMOs and primary care physicians: three-tiered HMOs and risk pools," *Med Care* 1992; 30:136-48.

enough to look at how the HMO pays the middle tier, policy makers must also look at the arrangements made by the middle-tier with individual providers.

The middle tier can use bonuses, withholds, or risk pools to transmit a portion of the risk to providers rather than complete risk. In comparing three-tiered HMOs and risk pools, Hillman argues that while they are conceptually and operationally different mechanisms, they play similar roles:

> they add a level of managerial authority, probably closer to the individual physician, but often with less complete power than a central HMO model; and
> they modify the sharing of risk between physician and central HMO, permitting other individuals, physician or non-physician, to share in that risk.

Hillman believes that many studies do not adequately distinguish three-tiered HMOs and may therefore overstate the amount of direct capitation. His survey found that only 35% of the plans ultimately paid physicians by capitation, and most of these were two-tiered plans. Further, only 19% of enrollment is in HMOs in which PCPs themselves receive direct capitation. Many middle tiers that receive capitated payment from the HMO transform this payment into salary or FFS for physicians. No plan turned a FFS payment into capitation of physicians.[18] This data is relatively out of date, but many HMOs appear to have three tier structures.

B. Primary Care Providers vs. Specialists

In early managed care arrangements, only PCPs were placed at financial risk, while most specialists were paid on a FFS basis. While this is still generally the case, the mix seems to be shifting. For example, the 1995 AMA physician survey found that PCPs receive a significant share of HMO reimbursement through capitation, while most specialty care physicians still are reimbursed on a FFS basis.[19] The 1995 PPRC report on health plans shows that the use of capitation arrangements is spreading into the area of specialist compensation. Although FFS is still the predominant method for paying specialists, 18% of plans report using capitation as their main method of payment for individual specialists. If plans using FFS compensation modified by bonus or withhold arrangements are included, over half of network or IPA managed care plans and three-quarters of group or staff HMOs pass some financial risks on to specialists. PPRC notes that its survey may even under-report the degree of specialist risk-sharing, because it does not capture plans' capitation of groups of specialists.[20]

Dr. Alan Zwerner of the American Medical Group Association has argued that specialty capitation will work in some situations but not all. First, for capitation to be effective, practitioners must have some control over the health outcome. If their ability to act proactively or react is limited, then capitation cannot work. For example, anesthesiologists have little control over the outcome of a surgery and are not involved in primary care, so it makes little sense to capitate their services. Second, risk sharing works better for low acuity, high frequency events because their costs are easier to predict. For example, putting neurosurgeons at risk for brain surgery, a high acuity, low frequency event may not be fair, since it is both expensive and

[18] Op-Cit., Hillman AL, Welch WP, Pauly MV, *Med Care* 1992.
[19] Op-Cit., Simon CJ, Emmons DW, *Health Affairs* 1997.
[20] Op-Cit., Gold M, et al., "Arrangements between managed care plans and physicians. Selected external research series no. 3.", 1995.

unpredictable. Third, the nature of the relationship between the PCP and the specialists with whom they contract can affect the decision to capitate. If the relationship is close and the PCP trusts the specialists to manage the care well, the PCP may be better off paying for services on a FFS basis. If the relationship is distant, the PCP may not trust the specialists to managed the care efficiently under FFS, then capitation might be a better option.

Capitation should only be undertaken if the health care system covers a substantial number of lives and if the capitation payment only covers services that are most often needed by the patient because health care systems might also want to purchase stop-loss insurance to protect against the high cost of some procedures performed by practitioners receiving modified FFS payments. In addition, risk adjusted payments to providers that blend prospective adjustments with FFS payments for less frequent conditions/procedures can alleviate some of the potential problems with capitation.[21]

C. Scope of Capitated Services

Health practitioners paid on a capitated basis can be at risk for a range of services, including only the services they provide, laboratory and other tests they order, all practitioner services, or all practitioner services plus some hospital services. According to Donald Berwick, "In order for capitation to be a force for the redesign of care processes, however, the entity paid by capitation – the one that stands to gain from innovation – must be capable of achieving such redesign." Based on this analysis, he recommends that "the services covered under capitated contracts should be those about which the risk-bearing entity can make relevant, clinically prudent choices, not those over which the entity has little or no influence or control." The GAO supports this conclusion in their 1988 report on physician incentive payments, recognizing that "shifting financial risk to physicians can place them in a compromising position when treating potentially expensive cases. If the HMO physician must pay for specialty or institutional service out of his or her own account, the physician has an obvious incentive not to use such services." This suggests, for example, that capitating PCPs for referrals to specialists is not desirable. Rather, alternative incentives for controlling inappropriate referrals should be considered. There is no currently available information about the extent to which practitioners in California are capitated for referral costs.

D. Size of Risk Group

Consensus seems to be forming in the health care community against incentive arrangements that apply to individual PCP services and referrals.[22][23][24][25] Hillman reported in 1987 that 18% of the HMOs responding to a survey held physicians at risk for deficits on the basis of their individual performance, as opposed to the collective performance of a group of physicians. He also found that for-profit plans are more likely than not-for-profit plans to place individual PCPs

[21] Newhouse J, "Patients At Risk: Health Reform and Risk Adjustment," *Health Affair*s, Spring (I) 1994, 133-146.
[22] Op-Cit., Latham S, *American Journal of Law & Medicine*, 1996.
[23] Berwick D, "Payment by Capitation and the Quality of Care," *NEJM* 1996; 335:1227-31.
[24] Op-Cit., The Advisory Board, Governance Committee Report, 1995.
[25] General Accounting Office, "Medicare: Physician Incentive Payments By Prepaid Health Plans Could Lower Quality Of Care," Washington, DC: Government Printing Office, 1988 (GAO/HRD-89-29).

at risk for deficits.[26] The PPRC survey found that among plans with withholds, 15% define the risk pool over which the withhold loss or gains is spread as the individual physician, 34% as a small group of physicians and 40% as all PCPs participating in the plan.[27]

The 1995 AMA Survey found that large practices are most likely to enter into capitated arrangements and that larger practices earn a greater share of practice revenues from capitated contracts than do smaller practices. However, 26.6% of solo practitioners and approximately 31.6% of physicians in practices with two to five physicians accepted capitated contracts in 1995.[28] Physicians in solo practices reported 16.8% of practice revenues were earned from capitated payments, compared to 37.5% of revenues in the largest groups.

Latham describes two major reasons for disfavoring one-practitioner incentive arrangements. First, one-practitioner plans spread risk over too few patients. Their cost-incentive effects are therefore too intense. The Advisory Board characterizes arrangements in which individual PCPs receive capitated payments for all professional services including referral costs for specialty care as "Nuclear Force Capitation" and notes that while they are "highly, inarguably effective," they are "hazardous in the absence of strong controls."[29] Latham writes that "plans that spread capitation over groups of five to 15 physicians seem greatly preferable from the consumer's point of view. This is a number small enough so that physicians' cost-control incentives are not diluted and the risk of physician free-riding is minimized but large enough to eliminate incentives that are potentially so strong as to override physicians' clinical judgment."[30] The second benefit Latham sees of insisting that incentive plans run to groups of practitioners rather than to individual practitioners,

> is that group-based incentives do not to depend for their efficacy solely on burdening individual clinical decisions. An incentive to a practice group is an incentive to cooperation among medical professionals in setting practice standards with which they can all live ethically and cost effectively.[31]

This position is supported by Berwick[32] and the GAO.[33]

Some physicians object to capitation of any group size. For individual practitioners, they agree that capitation is dangerous. As for groups, some private practice practitioners do not want to depend on others for their income. They feel that if they work harder, they should earn more.

E. Percent of Revenues at Risk

---

[26] Hillman A, "Financial incentives for physicians in HMOs: is there a conflict of interest?" *NEJM*, 1987; 317:1743-8.
[27] Op-Cit., Gold M, et al., "Arrangements between managed care plans and physicians. Selected external research series no. 3", 1995.
[28] Op-Cit., Simon CJ, Emmons DW, *Health Affairs* 1997.
[29] Op-Cit., The Advisory Board, Governance Committee Report, 1995.
[30] Op-Cit., Latham S, *American Journal of Law & Medicine*, 1996.
[31] Op-Cit., Latham S, *American Journal of Law & Medicine*, 1996.
[32] Berwick D, "Payment by Capitation and the Quality of Care," *NEJM* 1996; 335:1227-31.
[32] Op-Cit., The Advisory Board, Governance Committee Report, 1995.
[33] Op-Cit., General Accounting Office, "Medicare: Physician Incentive Payments By Prepaid Health Plans Could Lower Quality Of Care", 1988).

Berwick argues that "the magnitude of risk under capitation should not be so great as to influence an individual physician to make clinically imprudent choices for an individual patient." The 1995 AMA physician survey found that physician practices are bearing risk: among all practices with capitated contracts, nearly 20% of all revenues were capitated. Fifty-seven percent of physicians indicated that their practices earned 10% or less of total revenues from capitated payments; another 15% reported that only 11%-25% of revenues came from capitated contracts; and only 6.8% of physicians were in practices that earned 75% or more of revenues from capitated sources (see Figure 2).[34] In the PPRC survey, health plans reported an average of 12% as the maximum percentage by which an individual PCP's annual income may vary each year as a result of financial incentives.[35] More than a third of HMO managers surveyed by Hillman in 1988-89 believed that a withholding level equal to 16%-30% of HMO income should cause some concern.[36]

Further, in regulations governing physician incentive plans in prepaid health care organizations contracting with Medicare, the Health Care Financing Administration (HCFA) defines a physician or physician group as at substantial financial risk if the amount at risk for referral services exceeds 25% of potential payments for covered services.[37]

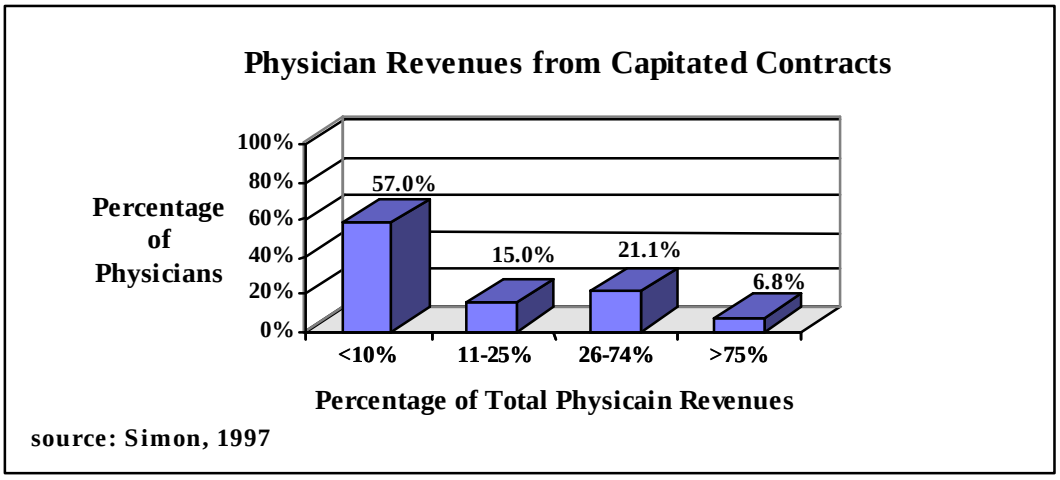

Figure 2

F. Frequency of Evaluation

Latham and the GAO report also discuss the impact that the frequency of incentive payment calculations can have on the intensity of the incentive felt by a physician. For example, an incentive plan that offers an annual bonus of $24,000 if a physician spends less than $120,000 on referral services in a given year is less intense than one that offers the same physician $2000

[34] Op-Cit., Simon CJ, Emmons DW, *Health Affairs* 1997.
[35] Op-Cit., Gold M, et al., "Arrangements between managed care plans and physicians. Selected external research series no. 3", 1995.
[36] Hillman A, Pauly M, Kerman K, Martinek C, "HMO managers' views on financial incentives and quality," *Health Affairs* (Millwood) 1991;10(4):207-19.
[37] HCFA Regulations 42CFR, Section 417.479.

in each month in which the physician spends less than $10,000 on referral services.[38] Latham argues that this is because

> costs are distributed over clinical decisions unequally. Extraordinarily high expenses for a single patient are averaged over the whole year in the former case, while in the latter case, those same high expenses are averaged over only a month's worth of patient encounters. In a shorter calculation period, even a single cost-outlier can impose the need for austerity measures if the incentive is to be earned.

The GAO also concluded that, "basing incentive payments on physician cost performances over a short period of time, such as a month, may increase the temptation to underprovide services".[39]

G. Thresholds

Several of the issues discussed above raise the question of whether or not thresholds exist above which financial incentives can be dangerous, and below which they have no effect. Finding the appropriate band seems to be the major challenge in structuring incentives.

Some areas where thresholds potentially may exist include:

Size of group. Regarding the size of the risk pool, Hillman was able to discern distinct thresholds necessary to reduce the impact of withhold account on physician decision making. He found that few managers believed that risk pools of only five physicians or fewer could counterbalance the impact of individual withhold accounts on decision making.[40] However, the health care industry has not formed a clear consensus on the appropriate group size.

Percent of income at risk. Latham mentions anecdotal evidence that suggests that "groups with over 40% of their income from "incentivized" plans reach a "tipping point" and begin to take incentive pressures seriously." Similarly, Hillman reports that "more than 90% of respondents reported no noticeable effect on the ordering behavior of physicians at risk as individuals if the level of withheld funds is below 5% of total HMO payments".[41]

H. Role of professional ethics and other non-financial incentives

Financial incentives are not the only method health plans use to encourage health practitioners to control utilization and provide cost-effective, quality health care. Other, arguably more, important factors at work include professional ethics and providers' desire for the esteem of their peers.

Zwerner notes that most medical groups include some measure of peer evaluation, patient satisfaction, contribution to the group, and patient volume in their bonus plans.[42] Supporters view these non-financial measures of quality as potentially an effective tool for changing provider behavior.

---

[38] Op-Cit., Latham S, *American Journal of Law & Medicine*, 1996.
[39] Op-Cit., General Accounting Office, "Medicare: Physician Incentive Payments By Prepaid Health Plans Could Lower Quality Of Care," 1988.
[40] Op-Cit., Hillman A, Pauly M, Kerman K, Martinek C, *Health Affairs*, 1991.
[41] Op-Cit., Hillman A, Pauly M, Kerman K, Martinek C, *Health Affairs*, 1991.
[42] Personal interview, June 10, 1997.

The PPRC study found that health plans used several different non-financial methods to influence medical practices. For example, 79% of group or staff HMOs and 70% of the network or IPA HMOs required outcome studies for particular clinical conditions. Sixty-nine percent of the group or staff HMOs and 80% of the network or IPA HMOs used physicians' profiles which measure physicians' practice patterns relative to their peers. Practice guidelines were used less often. In addition, the study found that many plans used non-financial factors to adjust payments. Some of the factors included patient complaint or grievance, quality measures, consumer surveys, provider productivity, and enrollee turnover rate.

Latham discusses other non-financial pressures that could serve to temper the intensity of financial incentives. These are: (1) marketplace competition based on quality of care; (2) the threat of medical malpractice liability if necessary care is denied; (3) utilization review and quality assurance review programs that operate to catch dangerous under-care directly and (4) physicians' professional ethics. He concludes, however, that possibly none of these pressures is strong enough to overcome a physician's self-interest in every case.

An additional, non-financial manner in which to shape provider practice patterns is to provide clinical practice guidelines. Hillman describes the role of clinical guidelines versus financial incentives in influencing physicians' clinical decisions. When an single acceptable standard of care exists for a clinical scenario, then management needs only to monitor for compliance. However, good practitioners often disagree about the best clinical approach. Hillman argues that the advantages of clinical guidelines are that they provide a mechanism to disseminate new knowledge about appropriate, effective methods of treatment. They afford explicit criteria for evaluating compliance with new clinical approaches and may help physicians justify withholding unnecessary services from a demanding patient; and if based on expert criteria and physician consensus, guidelines provide an opportunity to standardize the approach to some common medical problems, reducing confusion across treatment sites.

The peer pressure that results from groups of practitioners working together and sharing financial risk may be the most important non-financial influence on practitioner behavior. In Hillman's study of risk pools, he observes that,

> the advantages of risk pools may arise more from peer group effects (to intensify adherence to financial incentives or quality standards) than from the individual incentives themselves. Shifting the locus of managerial control through risk pools may be more important than shifting the financial risk.[43]

V. RESEARCH EVIDENCE

Although this paper focuses on the issues surrounding financial incentives for health practitioners in managed care plans, a related question is whether managed care plans can actually contain health care costs and utilization while maintaining or improving the quality of care provided. Several studies have documented different utilization patterns between various types of managed care plans and regular indemnity plans, but none have shown differences in

[43] Hillman AL, Pauly MV, Kertsein JJ, "How do financial incentives affect physicians' clinical decisions and the financial performance of health maintenance organizations?" *NEJM* 1989; 321:86-92.

quality attributable to financing mechanisms. This is largely due to the difficulty in measuring quality of care. In addition, several factors, such as potential selection bias, difficulty isolating variables, and characteristics of local market conditions may cloud the results of the utilization studies.

Hillman in 1989 concluded that some financial incentives as well as the type of HMO can influence the behavior of physicians toward patients. Hillman surveyed HMOs and found that capitation and salary-based payment as well as group-model and for-profit status were associated with lower hospitalization rates. He also found that physicians with a higher proportion of HMO enrollees in their caseload were associated with more frequent outpatient visits for primary care per enrollee. Placing physicians at financial risk and imposing penalties for HMO hospital referral deficits beyond the loss of withheld funds were associated with less frequent outpatient visits by enrollees to PCPs, holding all else constant.[44] Although some of these factors affect physician behavior, their effect on quality of care remains to be determined.

A 1995 study of managed care and capitation in California by Eve Kerr of UCLA discusses what she terms "internally imposed utilization management." These are utilization management techniques that provider groups are initiating in response to capitation. Kerr argues that when medical groups and IPAs receive capitation from a health plan, the practitioners gain both managerial and financial control. In order to profit, their costs must be lower than the capitated payments. This financial risk "has challenged physicians to develop effective ways to manage their own utilization and costs while maintaining quality of care for capitated patients. Of the 133 groups surveyed, all used primary care gatekeeping and reauthorization, 79% retrospectively profiled physician's utilization patterns, 70% used practice guidelines, and 69% had instituted some form of managed care education (see Figure 3). Further, 62% indicated that "financial control" had the greatest influence on the structure of the group's utilization management strategy, compared to 23% who indicated "quality of care provided" as the greatest influence".[45]

Finally, Robinson's study of six large medical groups paid through capitation in California found hospital utilization rates for HMO enrollees served by capitated medical groups to be 40% below the California average for all enrollees in commercial HMOs. The groups had rates of physician visits per enrollee in 1994 that were slightly lower than those for all California HMOs. These medical groups were all financially at risk for the cost of care and all managed utilization through their own medical directors and physician committees.[46]

[44] Op-Cit., Hillman AL, Pauly MV, Kertsein JJ,*NEJM* 1989.
[45] Kerr EA, Mittman BS, Hays RD, Siu AL, Leake B, Brooke RH, "Managed care and capitation in California: how do physicians at financial risk control their own utilization?" *Ann Intern Med*, 1995; 123:500-4.
[46] Robinson JC, Casalino L, "The growth of medical groups paid through capitation in California," *NEJM* 1995; 333:1684-87.

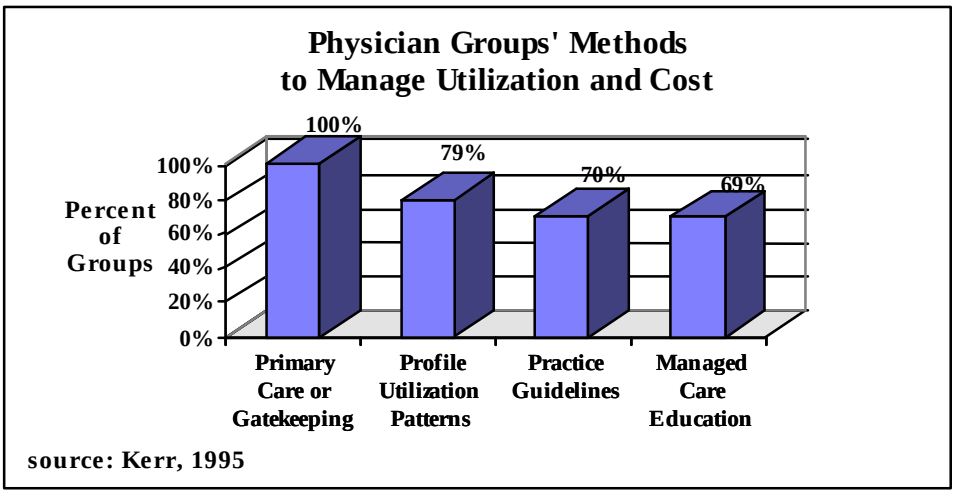

Figure 3

VI. GOVERNMENT RESPONSES

In response to concerns about financial incentives in managed care, governments at both the Federal and State level have taken actions to try to prevent the most egregious situations.

A. Federal Regulation

Federal actions governing financial incentives for practitioners have had mixed goals. Antitrust actions in the late 1980s led to a ruling favoring the use of incentive arrangements in creating managed care provider networks. Incentive arrangements, where providers share the risks of loss as well as of profit, provide antitrust enforcers a way to identify genuine network formation. According to Latham,

> the 1994 Statements of Department of Justice (DOJ) and Federal Trade Commission (FTC) Enforcement Policy on Physician Network Joint Ventures made clear that, for physicians to be immune from antitrust challenge, 'the physicians participating in a physician network joint venture must share substantial financial risk.' As specific examples of shared financial risk, the statements included capitated payments and the use of financial incentives such as withholds distributed to physicians, 'only if…cost containment goals are met.'

Since then, the DOJ and FTC have somewhat softened their position. Their 1996 Statement says that, "[P]hysician network joint ventures that do not involve the sharing of substantial financial risk also may be lawful if the physicians' integration through the joint venture creates significant efficiencies and the venture, on balance, is not anti-competitive." Federal antitrust enforcers, then, have consistently viewed physician incentive plans as indicative of managed care integration. They have therefore favored their use.

At around the same time the Federal government was developing its antitrust policies for physician networks, Congress came close to banning all physician incentive plans. Congressional action was in response to incentive plans like that offered by one physician network. According to the GAO, the company's plan

> included a combination of features that together could provide hospital physicians too strong an incentive to undertreat patients. The Paracelsus plan distributed incentive funds monthly based on each individual physician's performance in contributing to the hospital's revenues…As a result of the Paracelsus case and concerns that other physicians may respond inappropriately to financial incentives, the Congress, through section 9391 of the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986), prohibited, effective April 21, 1987, direct or indirect incentive payments by Medicare participating hospitals to physicians to reduce or limit services. The provision also prohibited HMOs with Medicare (or Medicaid) risk contracts from making such incentive payments, effective 1989.[47]

Congress postponed the effective date for this second provision covering HMOs in both OBRA 87 and OBRA 89. Congress then repealed the provision in OBRA 1990, replacing it with related language.

Latham writes that, "[b]y 1990, then, Congress recognized the importance of managed care incentive schemes in keeping health costs down. The movement to ban all such plans was dead; only hospital-sponsored incentive plans were outlawed." In 1993, Congress passed the Ethics in Patient Referrals Act, commonly known as the Stark law. In general,

> the Stark law prohibits any payment to a physician that is tied to that physician's referral record. True to the new congressional concern with keeping health care costs down, however, the law makes an explicit exception for physician incentive programs that are designed to reduce referrals through bonus or withhold payments. The only limitation to the exception is that payments may not be made to a physician or physician group as an inducement to limit services to a specific individual enrollee.[48]

The OBRA 1990 provisions (Sections 4204(a) and 4731, Public Law 101-508) permit physician incentive plans for Medicare-participating HMOs under certain circumstances. HCFA published final regulations (42CFR, Section 417.479) implementing these provisions in March 1996 which went into effect January 1, 1997. The rules, which apply only to those physician incentive plans that base compensation on the use or cost of referral services, have three main provisions. First, Medicare managed care plans may not operate incentive programs under which payments are made to individual physicians on the basis of their experience with individual patients. Second, managed care plans must disclose to HCFA their incentive plan arrangements in such detail as to allow HCFA to determine compliance of the arrangements with the regulations. Finally, if the incentive plan puts a physician or physician group at "substantial financial risk" for referral services: 1) there must be adequate and appropriate stop-loss protection, and 2) the managed care organization must survey current and previously enrolled members to assess member access to and satisfaction with the quality of services. HCFA defines "substantial financial risk" to exist if a physician or physician group is at risk for

[47] Op-Cit., General Accounting Office, "Medicare: Physician Incentive Payments By Prepaid Health Plans Could Lower Quality Of Care," 1988.
[48] Op-Cit., Latham S, *American Journal of Law & Medicine*, 1996.

more than 25% of their largest possible annual income, inclusive of bonus or other incentive payments.

B. State Regulation

The California legislature passed AB 2649 in 1996, imposing two new requirements on health plans. The first prohibits certain incentive plans that limit the provision of specific, medically necessary and appropriate services provided to an enrollee or a group of enrollees with similar medical conditions. The language does not prohibit incentive plans that reward preventive care or are designed to reward appropriate levels of care, nor does the law prohibit capitation or other shared-risk arrangements that are not tied to specific medical decisions involving specified enrollees or groups of enrollees. The second requirement deals with disclosure of incentive plans to consumers (see below).

Some organizations believe that AB 2649 is inadequate in several respects. The CMA supports a specific prohibition against any incentive to induce a practitioner to change a treatment plan. They also believe there is need for greater monitoring and enforcement of the existing law. In addition, the CMA supports annual submissions by health plans of an actuarial report containing an opinion of a qualified actuary as to whether the capitation-based payment arrangements are computed appropriately.

C. Disclosure of Financial Incentives

Many believe that health care consumers would be better off if they were informed about the financial incentives that might affect their practitioner's behavior. Those for whom financial incentives were important could switch provider groups or even health plans on the basis of this information. Others would simply be aware of the incentives and more inclined to question whether financial incentives played a role in practitioner decisions about their care. In addition, with disclosure, some undesirable incentive arrangements might be voluntarily modified. Several steps have been taken at both the federal and state level to increase the amount of information that health plans and provider groups must disclose. However, there is little evidence as to how consumers use the information that is available.

1. Disclosure To Regulators

In order to determine compliance with regulations described above, HCFA requires Medicare and Medicaid managed care plans to disclose information about both its direct contracting arrangements and its subcontracting arrangements. Provider groups that transfer substantial financial risk, and all other contacting relationships regardless of the level of risk transferred, must disclose the following information to HCFA on an annual basis: (1) whether referral services are covered by the incentive plan. If only services furnished by the physician group are addressed by the incentive plan, then there is no need for disclosure of other aspects of the incentive plan; (2) type of arrangement (e.g. withhold, bonus, capitation); (3) percent of total income at risk for referrals; (4) amount and type of stop-loss protection; (5) panel size and whether enrollees are pooled to achieve the panel size; (6) percentage data from the previous calendar year showing how capitation payments paid to PCPs were used to pay for primary care services, referral services to specialists, hospital services, and other types of providers; and (7) if the managed care organization is required by the regulation to conduct a customer satisfaction survey, a summary of the survey results.

In California, health plans seeking an HMO license must apply to the Department of Corporations (DOC). The application requires detailed financial information, including a copy of any contract between the health plan and any provider. Periodically, the DOC reviews and analyzes practitioner incentive information. The financial information submitted to the DOC is considered confidential and is not available to the public nor to researchers, even in aggregate form.

2. Disclosure To Consumers

In addition to HCFA's requirement that Medicare managed care plans disclose information about their physician incentive plans, HCFA also requires that contracting managed care plans disclose to Medicare or Medicaid beneficiaries who request it, information indicating whether the managed care organization or any of its contractors or subcontractors uses an incentive plan that may affect the use of referral services, the type of incentive arrangements used, and whether stop-loss protection is required. If the managed care organization is required to conduct a survey, it must also provide beneficiary requesters with a summary of survey results. HCFA suggests that health plans include instructions about how to request this information in their pre-enrollment materials and in their Evidence of Coverage.

California bill AB 2649 of 1996, now part of Section 1367.10 of Knox-Keene, includes the requirement that every health service plan "include within its disclosure form and within its evidence or certificate of coverage...the basic method of reimbursement, and whether financial bonuses or incentives are used." The idea that consumers should be able to be informed of the general character of the financial incentives possibly bearing on their own practitioners' decisions is reasonable and appealing. This can be material information. Such disclosure could go a long way toward clearing up the suspicion that exists today.

The main problems with disclosure are practical. For the most part, health plans do not pay practitioners directly. They pay participating provider groups (PPGs), i.e., medical groups and IPAs, and PPGs pay practitioners. Health plans contract with many PPGs. For example, one California plan contracts with over 190.[49] It would be extremely difficult for the health plans to include a report of each relevant PPG's payment methods in its evidence of coverage booklet for each employment groups. PPGs are often reluctant to share this information with health plans, considering it proprietary information. Furthermore, the payment methods used by PPGs are complex and fluid. The methods can vary by specialty and other particular circumstances. PPGs also may pay practitioners differently depending on the health plan, and some PPGs serve a dozen or more health plans' patients as well as those covered under preferred provider insurance and other FFS arrangements. The practical implementation of disclosure thus becomes extremely complex and costly. It is therefore not surprising that HCFA and DOC have so far accepted statements disclosing the variety of payment methods used in each health plan in general, and not requiring statements by PPG or practitioner. Therefore, the apparent intent of AB 2649 is not yet being implemented in practice.

[49] Information submitted to the Managed Health Care Improvement Task Force, 1997.

One way to further this intention is for the legislature to grant DOC the authority to demand the disclosure statements from contracting medical groups and IPAs, and to specify the conditions under which they must be disclosed to consumers. However, it would be wise for DOC to precede general implementation with a demonstration project to permit assessment of which types of disclosure are most useful, and their costs and benefits, before full implementation is directed.

The AMA believes that to fully exercise their autonomy, patients need to be fully informed about the philosophy and goals of managed care. In its 1990 report, the AMA Council on Ethical and Judicial Affairs stated that "the physician's responsibilities under managed care include a duty to disclose to the patient conflicts of interest that may affect patient care and medical alternatives that cannot be offered because of restrictions of the managed care plan." That report specifically states that "physicians have a duty to disclose financial incentives, to disclose contractual agreements restricting referral, and to ensure that the managed care plan makes adequate disclosure of the details of the plan subscribers." In updated findings the Council recommends that "[p]hysicians also should continue to promote full disclosure to patients enrolled in managed care organizations. The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patients' managed care plans." In addition, "any incentives to limit care must be disclosed fully to patients by plan administrators on enrollment and at least annually thereafter."[50]

The CMA believes that health plans should be required to inform current and potential members, in easy to understand language, what specific incentives (e.g., withholds, bonuses) they use to influence their providers' health care recommendations.

VII. CONCLUSION

The discussion of financial incentives for health practitioners in managed care plans raises the question of whether there are incentive arrangements that are inconsistent with the interest of patients and should be prohibited. The goal of any regulation should be to align the incentives of the health plan, the practitioners, the patients, and the ultimate payers (taxpayers, workers). Appropriate and transparent incentive arrangements are also important in restoring and maintaining trust in individual practitioners, entities, and the health care system as a whole. The outcome should be the provision of good quality, cost-effective health care. One way to contain the most egregious type of financial incentives might be to try to minimize the intensity of financial incentives felt by the practitioner. It is likely that the debate about appropriate financial incentives for practitioners in managed care arrangements will persist until the quality measurement problem has been solved.

VIII. RECOMMENDATIONS

1. Health plans should be required to disclose to the public the general methods of payment made to their contracting medical groups/IPAs or health practitioners and the types of financial incentives used. Disclosure should use clear and simple language, including a

[50] AMA, Ethical Issues in Managed Care, (Council on Ethical and Judicial Affairs, American Medical Association) *JAMA* 1995; 273(4): 330

suggestion that if an individual wishes to know more about their providers' or provider groups' method of reimbursement, they can ask their medical group/IPA, provider, or health plan.

2. The DOC should conduct a pilot project with a variety of medical groups and other provider groups to develop clear, simple, and appropriate disclosure language (field-tested for consumer understanding and value) and the most cost-effective methods for distribution to enrollees. The DOC should report results back to the legislature to consider how best to approach provider group disclosure.

3. Provider groups and health practitioners should be required to disclose the method of compensation and financial incentives they receive, upon the request of a patient. Provider groups should also be required to disclose the methods of compensation and incentives paid to their subcontracting providers.

4. (a) Health plans and provider groups should be prohibited from adopting an incentive arrangement in which an individual health practitioner receives a capitation payment for professional services that includes the cost of referrals for that practitioner's patients.
(b) Where an individual health practitioner receives an incentive tied to the cost of referral of that practitioner's patients or where a very small group receives such an incentive or a capitation payment for professional services that includes the cost of referrals for the group's patients, it should not be approved by the DOC in the absence of a determination that there is a patient panel of sufficient size to spread risk and there are adequate provisions to assure quality care and to protect against high risk cases through stop-loss or risk adjustment.
(c) The federal rule requiring the provision of stop-loss coverage for health practitioners at substantial financial risk should be extended by state law to practitioners treating commercial patients.

5. Sponsored purchasing groups, such as PBGH, and accreditation organizations, such as NCQA, should review provider incentive compensation arrangements (including non-financial incentives) to identify best practices and practices in need of improvement, and seek to influence plan and provider groups accordingly. Particular attention should be paid to the promotion of risk factor measurement (e.g., morbidity and mortality rates) and risk adjustment.

6. An industry group should be formed by the California Medical Association, California Association of Health Plans, American Medical Group Association, and the National IPA Association to review provider compensation arrangements, identify best practices and practices in need of improvement, and advise regarding the need for changes in regulatory oversight.

7. Major purchasers should consider Task Force recommendations to them regarding risk adjustment (See recommendations in Task Force paper on Risk Avoidance).

IX. OTHER OPTIONS CONSIDERED

Further disclosure requirements could include requiring health practitioners to disclose affirmatively the method of payment received and the types of financial bonuses they receive.

Other limitations on incentive arrangements could include (a) prohibiting incentive payments to an individual practitioner tied to the cost or use of referrals for that practitioner's patients, and (b) prohibiting capitation payments or incentive payments to small groups of practitioners (e.g., 2-5 practitioners) for professional services that includes that cost of referrals for the group's patients.